UC SANTA CRUZ

Verification of Health Condition Form

When requested by your college as part of the readmission process, this form should be sent by U.S. mail or FAX to the UCSC Student Health Center, Attn: Case Management, 1156 High St., Santa Cruz, CA 95064 or FAX: 831-459-3546.

Dear Provider:

Thank you for treating our UC Santa Cruz student. We ask that you complete this form to

1) document the student's recent medical/mental health condition;

2) provide your opinion regarding the impact this condition has had on their academic performance;

3) inform whether the condition has sufficiently resolved OR that the student is receiving treatment that should enable them to be academically successful.

To assist you in this endeavor, we want to give some context about the process. Appeals to a denial to academic majors are considered for students when an overwhelming medical or mental health concern made it impossible for them to perform at a level that allowed them to be successful in our rigorous course of study FOR A PERIOD OF TIME, AND that the impairing condition has resolved, or is improving sufficiently to expect success with academic endeavors.

Thank you for taking a few minutes to complete the attached form. As the treating clinician , we depend on your partnership to give us a clear picture of the treatment the student has received, the progress they have made, and their ongoing treatment needs. On the form, the student has consented for us to contact you if we have any questions or need further clarification. This information is being reviewed by health care professionals at the UC Santa Cruz. We will then share your conclusions with the MCD Biology department. The health information will be securely stored in our Electronic Health Record and will not be shared with the academic department.

For any questions about this process please contact Jenner Rosgen at 831-459-2895.

Thank you.

Jenner Rosgen, M.A., L.M.F.T

_____ Please initial here indicating you have read and understand this information

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Part A: Health Condition Academic Impact Form

Student name: _____ ID#: _____

Which dates did your health condition affect your academic performance : _____

Name of physician or health care provider: _____

Office address: _____

Telephone number: _____

Authorization for Release of Information

I authorize the Health Care Provider above to provide the following information regarding my medical history and condition(s) to UCSC Student Health Center employees. I further authorize the Health Care Provider above to provide additional information regarding my medical condition and recommendations for ongoing treatment to the Case Manager, or designee of the UCSC Student Health Center, if requested.

I also acknowledge and agree that the conclusions of my provider will be shared with my academic department

Student signature: _____ Date: _____

Part B: To the Physician or Health Care Provider

This student is requesting documentation of a health condition that may have impacted his/her ability to successfully complete required coursework. Please respond to the following questions to the best of your ability, to **address the impact of the student's condition on ability to complete previous required coursework and ability to complete required coursework successfully going forward.** When completed, please return this form to the student, who will then submit it to the UCSC Student Health Center.

Please briefly describe the student's health condition, the treatment you provided to the student and how the condition has changed.

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(Part B Continued)

Please describe your current treatment and any recommended ongoing treatment plan that will be required for the student to succeed academically. Please indicate who will be providing this treatment. (Please note: if there is an expectation that treatment will be provided by the UCSC Student Health Center (831-459-2211) or Counseling and Psychological Services (CAPS, 831-459-2628), student must contact us prior to finalizing the appeals process.

I have treated the student for this condition and, in my professional judgement:

☐ the condition likely impacted academic performance

☐ the condition is not likely to have impacted academic performance

☐ I did not care for the student during the period in question, or have no record of this condition

Please choose one:

☐ The recommended treatment plan is currently in place that is likely to result in improved academic performance

☐ The recommended treatment plan is not yet in place

☐ No ongoing treatment plan is necessary

Signature of Physician/Health Care Provider:_____

Date: _____

Degree: _____ **State:** _____ **License No.:** _____